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## Healthcare: Between a Human and a Conventional Right

One of the hallmarks of human civilization is the extent to which societies take care of their most vulnerable members, especially the sick and disabled. Many countries have outlined public policies committed to providing healthcare for those who cannot provide for themselves. Such policies have various rationales, such as reducing suffering, providing for the least well-off, improving health to create fair opportunity in life, and so on. One of the most prevalent rationales for public healthcare policies is a human right to healthcare.

Understanding healthcare as a universal human right demands recognizing individuals' entitlements to claim healthcare resources that prevent and cure disease, ameliorate disability, and enhance wellbeing, regardless of their political membership or social and economic status. One of the most important challenges for the defenders of a human right to healthcare is the allocation of resources for its realization. One problem is that, as Onora O'Neill and Gopal Sreenivasan argue, it is not immediately clear which agents bear the correlative duties for the right.<sup>1</sup> Governments are typically considered the duty bearers, but they differ vastly in their capacity to help those vulnerable to health setbacks and those with severe disabilities.<sup>2</sup> At the extreme, a right to healthcare is out of the reach of many developing economies that struggle to provide the most basic services to their citizens. All governments operate under scarcity, but those operating under severe scarcity can be judicious in their use of public resources, yet fail to provide even the most basic healthcare goods and services.

The differential ability to provide healthcare services is deployed in arguments rejecting the existence of a human right to health. Here is one form such argument can take:

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<sup>1</sup> Onora O'Neill, "The Dark Side of Human Rights," *International Affairs* 81, no. 2 (March 1, 2005): 427–39; Gopal Sreenivasan, "A Human Right to Health? Some Inconclusive Scepticism," *Aristotelian Society Supplementary Volume* 86, no. 1 (June 1, 2012): 239–65.

<sup>2</sup> Jonathan Wolff, *The Human Right to Health*, 1 edition (W. W. Norton & Company, 2013), 29. Strictly speaking, the right is borne by members of the public, and discharged through government agents acting on their behalf. For shorthand, though, I will simply refer to governments as duty bearers.

**Premises:**

1. Human rights are universal.
2. The existence of universal human rights implies the existence of agents with the capacity to discharge their duties towards individuals who possess human rights (the 'ought implies can' condition).
3. If a right to healthcare were a universal human right, it would require access to equal treatment for holders of the right.
4. Due to objective scarcity, many agents (countries) can provide neither access equal to the most developed countries, nor access to basic health services. Such inability is not blameworthy.

**Conclusion:**

5. Since many agents cannot discharge their duties with respect to a human right to healthcare, there is no human right to healthcare.

Premise 4 is the most controversial of these, and has received considerable attention from both critics and supporters of human rights to healthcare. Sreenivasan in particular has deployed the scarcity constraint as a reason to reject the claim that a human right to healthcare exists. In a brief but important section of his article "A Human Right to Health? Some Inconclusive Scepticism," Sreenivasan argues that if human rights to provision of healthcare services existed, then governments would be violating rights without doing anything wrong.<sup>3</sup>

I will provide additional reasons in defense of premise 4, by showing that the challenge is more fundamental than even Sreenivasan allows, and justifies further skepticism for a human right to healthcare. Various agents tasked with providing healthcare services to those who possess a human right to healthcare not only face scarcity constraints, namely a lack of financial resources, but often a more critical shortcoming of institutional capacity, which is related to financial capacity, but distinct from it in ways that I will make clear. The institutions and infrastructure that deliver healthcare services cannot be created ex nihilo or significantly improved by a simple re-allocation of financial resources, and wide variation in institutional

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<sup>3</sup> Sreenivasan, "II—A Human Right to Health?," 245–46.

capacity among states is likely to be a permanent feature of our political landscape for the foreseeable future.

While all of the premises spelled out above are contestable, I will assume for the sake of argument the truth of premises 1 and 2, namely 1. the universality of human rights, and 2. the ‘ought implies can’ condition. I take 3, the requirement of equal access to healthcare services or ‘equal provision’ to be a direct implication of 1. This assumption allows me to focus the rest of the argument on explaining the significance of premise 4 whose truth, together with 1-3, shows that when doing nothing wrong violates an alleged human right, the idea that the right in question is a *human* right needs to give way. The more general principle is this: *if duty-bearers can routinely violate a human right without doing anything wrong, the human right in question does not exist*. It is not the implication of this argument that governments do not have responsibilities towards their citizens for the provision of healthcare services, only that those responsibilities are not best understood in terms of human rights.

Section one will give an overview of various justifications for a human right to healthcare. Section two will discuss the resource and institutional capacity condition as an objection to the existence of a human right to healthcare. Section three will address objections to this argument that rely on the need to provide healthcare not at a level equal to the most advanced economies but a decent minimum. I show that several promising ways of specifying a decent minimum face serious difficulties. These specifications build on some of general justifications offered in section one. Section four takes up another challenge to the institutional capacity problem, namely the progressive realization view, and argues that if one adopts it as condition associated with a human right to health, one has already given up the idea of a human right to healthcare. Finally, I offer an alternative understanding of healthcare rights as legal-conventional rights enacted by communities in pursuit of distinctive goals related to health and equal opportunity.

A conventional right is a right that emerges from policies enacted by governments in pursuit of certain moral goals. Political communities may pursue a number of moral goals, such as reducing suffering, closing opportunity gaps for the disadvantaged, and preventing the spread of contagious diseases. In doing so they enact policies that create specific healthcare

entitlements for various groups of people on the basis of those goals. These entitlements will depend on the available institutional capacity and resources, and on trade-offs with other important policy goals. We need not think of these *moral goals* as promoting or protecting human rights.

The argument fits into a broader debate about the connection between human rights and the requirements of social justice broadly conceived. It provides support for the position that human rights do not have to realize all the requirements of social justice, but can be limited to a subset of those requirements. John Rawls, Joel Feinberg, and Charles R. Beitz have all defended a version of this position.<sup>4</sup> Although they disagree on which rights belong to the proper subset of human rights, they all maintain that some of the values often referred to as human rights are best understood as ‘aspirational’ or ‘manifesto’ rights, and that these are not human rights proper, but rights created by political communities in pursuit of their (often distinct) visions of social justice. The argument offered here substantiates this position with respect to the right to healthcare.

## I. From Human Rights to Healthcare Rights.

Human rights are distinct from other rights in virtue of their *universality*—human rights are rights that every human being enjoys, and their *institutional independence*—they exist independently of the political and social context in which individuals find themselves. Violating human rights involves committing a moral wrong against the individual rights bearer.

In *Making Sense of Human Rights*, James Nickel captured some of the fundamental features of human rights. Human rights offer

basic moral guarantees that people in all countries and cultures allegedly have simply because they are people. Calling these guarantees "rights" suggests that they attach to particular individuals who can invoke them, that they are of high priority, and that

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<sup>4</sup> John Rawls, *The Law of Peoples: With "The Idea of Public Reason Revisited,"* 1st ed. (Harvard University Press, 2001), 81; Charles R. Beitz, *The Idea of Human Rights* (Oxford University Press, USA, 2009), 142–43; Joel Feinberg, *Social Philosophy* (Englewood Cliffs, NJ: Prentice-Hall, 1973), 67.

compliance with them is mandatory rather than discretionary. Human rights are frequently held to be universal in the sense that all people have and should enjoy them, and to be independent in the sense that they exist and are available as standards of justification and criticism whether or not they are recognized and implemented by the legal system or officials of a country.<sup>5</sup>

These features of human rights are familiar. Human rights are fundamental rights that people enjoy by virtue of their common humanity. This means that they are universal, timeless and exist independently of the particular political institutions one happens to live under. Human rights are claim rights against anyone and everyone, so each person has the duty to respect the human rights of everyone else.

Universality has three dimensions. First, universality applies to the subjects of rights - the rights holders. Every human being, without qualification, is a right holder. Second, universality applies to the subject of duties – the duty bearer. Every human being is under a duty to respect these rights. This implies capacity to discharge the duty under normal circumstances – ‘ought implies can.’ Third, universality applies to the kind of treatment (action or forbearance) that rights bearers are due and duty holders owe. All right holders are entitled to equal treatment, the same kinds of action or forbearance from others.

The understanding of what is owed to the holder of a human right can change. What it is to respect a right to bodily integrity can change when our understanding of threats to life and safety evolves. For example, if technology permits me to build a device that emits sound waves that permanently damage your hearing, my use of that device could constitute a new kind of violation of your bodily integrity. Nonetheless, each human right has a stable core that is time-invariant. Individuals in ancient Greece had a human right to freedom that included a right not to be enslaved – even the ones who were in fact enslaved – no less than individuals living today do.

Institutional independence means that human rights exist outside of the actual institutional machinery of states. They offer guidance for behavior and can be claimed by right

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<sup>5</sup> James Nickel, *Making Sense of Human Rights*, 2nd ed. (Wiley-Blackwell, 2007), 561–62.

holders in contexts where institutions, understood as organizations collectively authorized to provide goods or restore order, are not available or have collapsed. A right against being arbitrarily killed or enslaved can be claimed by rights holders in pre-institutional or non-institutional settings, such as by astronauts on the moon, or by individuals living in a failed state. Indeed, this is the only way human rights can serve their functions of both guiding and evaluating behavior, by generating principles of right conduct and by helping to assess the extent to which individuals and institutions comply with those principles.

Several general rationales for human rights have been put forward as the basis of a human right to healthcare. This (non-exclusive) list of justifications draws on the general functions human rights serve:

1. rights as protectors of fundamental interests against standard threats (interest-based accounts);
2. rights as protectors of human dignity (status-based accounts);
3. rights as instruments for achieving an optimal distribution of advantages (fair opportunity accounts); and
4. rights defined as principles of right treatment ‘that would be chosen by properly situated and motivated agents agreeing to the basic terms of their relations’ (contractarian accounts).<sup>6</sup>

I will provide a brief description of these four general accounts of rights, explain how a human right to healthcare derives from the general accounts, and then raise some questions about the features that qualify it as a human right.

#### 1. Interest-based accounts.

A well-known account of rights says that they protect fundamental interests against standard threats. Joel Feinberg describes interests as stakes people have in certain states of affairs. Not all interests are important, but some constitute ‘distinguishable components of a person’s wellbeing’, such as physical security, nourishment, health, and resources to pursue

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<sup>6</sup> This classification overlaps broadly with the one offered by Leif Wenar, “Rights,” ed. Edward N. Zalta, *The Stanford Encyclopedia of Philosophy*, n.d., <<http://plato.stanford.edu/archives/fall2015/entries/rights/>>.

one's goals.<sup>7</sup> Rights violations constitute important setbacks to such interests. However, not all setbacks to interests are rights violations. Feinberg believes that many classes of setbacks to interest should be excluded: those that the victim has consented to by making risky bets which set back one's financial interest, or those that result from fair competition between businesses vying for the same customers.<sup>8</sup> The practice of competition may result in setback to substantive interests, but such harm should not induce moral liability in the winner because those setbacks are part of a general practice that is conducive to the well-being of each participant in the practice.<sup>9</sup>

Human rights can piggyback on this general account of rights as protectors of fundamental interests. Violations of human rights involve invasions of an interest in bodily integrity, sustenance, or property. Jonathan Wolff provides the most well-developed and sophisticated application of this general account to a right to health, conceiving a right to health as a right to be protected against standard threats to health.<sup>10</sup> Wolff defines a standard threat to health as a condition that 'first, it is serious enough to count as a threat, and second, a solution could reasonably be expected to be in reach, either because treatment could be made available on a routine basis, or because the condition is widespread and urgent and there is every reason to think that the normal processes of scientific research would lead to a solution.'<sup>11</sup> Such a right grounds both negative duties not to disable or make people sick, and positive duties for governments as well as other agents (pharmaceutical companies, rich nations, and international organizations) to protect and promote the health of others.<sup>12</sup>

Wolff defends a right to *health*, not a right to *healthcare*, because there are many determinants of health besides healthcare, such as hygiene, sanitation, nutrition, and housing. But he emphasizes that such a right cannot be conceived as a right to be healthy, since the

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<sup>7</sup> Joel Feinberg, *Harm to Others* (Oxford University Press, USA, 1987), 34.

<sup>8</sup> Feinberg, 42.

<sup>9</sup> Carmen Pavel, "Negative Duties, the WTO and the Harm Argument," *Political Studies*, February 1, 2014, 6.

<sup>10</sup> Jonathan Wolff, "The Demands of the Human Right to Health," *Aristotelian Society Supplementary Volume* 86, no. 1 (2012): 222; Henry Shue, *Basic Rights*, 2 Sub (Princeton University Press, 1996).

<sup>11</sup> Wolff, "The Demands of the Human Right to Health," 223.

<sup>12</sup> Wolff, *The Human Right to Health*, 18–35; Allen Buchanan, *Justice and Health Care: Selected Essays*, 1 edition (New York: Oxford University Press, 2009), 219–30; John Tasioulas and Effy Vayena, "Just Global Health: Integrating Human Rights and Common Goods," SSRN Scholarly Paper (Rochester, NY: Social Science Research Network, May 21, 2015), 3, <http://papers.ssrn.com/abstract=2608938>.



‘contingencies of genetics and biology make it impossible to ensure that everyone remains healthy.’<sup>13</sup> Many have rejected his radically inclusive notion of a right to health that includes all the determinants of health. It seems to absorb within it every other right, good, and interest that bears positively on our health – all rights turn out ultimately to be rights to health, making talk of other human rights superfluous.<sup>14</sup> For these reasons, and to focus the discussion, I will refer to a right to healthcare – a right to the provision of health-related goods and services – as opposed to a right to health.

## 2. Status-based accounts.

Status-based accounts see the role of human rights as protecting moral agency – the ability to form, revise and pursue conceptions of a good life – and as such they constitute a source of moral dignity to be protected against the interference of others. Rights to freedom of conscience, freedom to plan and live our lives, and freedom from physical aggression all protect moral agency. Various described as protecting human standing, personhood, human dignity, or moral agency, human rights protect moral status.<sup>15</sup>

A human right to healthcare can be conceived as a right that is especially important for protecting the physical and mental health necessary for the exercise of moral agency. Individuals affected by serious, crippling disease or disability, who lack support for either medical treatment or assistance, cannot meet the necessary conditions for either forming or executing a plan of life. The case for rights to welfare ‘appeals to our picture of human agency and argues that both life and certain supporting goods are integral to it. Life and certain supporting goods are necessary conditions of being autonomous and free.’<sup>16</sup> Leisure, education and healthcare are among these supporting goods.

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<sup>13</sup> Wolff, “The Demands of the Human Right to Health,” 222.

<sup>14</sup> Tasioulas and Vayena, “Just Global Health,” 6.

<sup>15</sup> James Griffin, *On Human Rights*, 1 edition (Oxford University Press, 2009), 4, 33; Alan Gewirth, *Human Rights: Essays on Justification and Applications*, n edition (Chicago: The University of Chicago Press, 1983); James Nickel, “Human Rights,” *The Stanford Encyclopedia of Philosophy*, 2014, <http://plato.stanford.edu/archives/win2014/entries/rights-human/>.

<sup>16</sup> James Griffin, *On Human Rights*, 180.

### 3. Fair opportunity accounts.

The third account for a human right to healthcare comes from the idea that rights create fair opportunities for individuals in societies with large differentials in life chances. Norman Daniels prefers an account of rights to healthcare tied to universal human needs, such as food, shelter, clothing, exercise, food and companionship, things necessary for 'species-typical normal functioning.'<sup>17</sup> Not having these needs met reduces the range of opportunities available for individuals to plan and live their lives.<sup>18</sup> It is by distributing the range of services and benefits associated with healthcare and other goods that we preserve normal species functioning. More recently, Daniels has recast this argument to defend the *special importance* of health. Building on his earlier work and on Rawlsian 'justice as fairness,' in *Just Health* he argues that health, and consequently a right to healthcare, is especially weighty in promoting fair opportunity.<sup>19</sup>

Tom L. Beauchamp and James F. Childress outline another version of the 'fair opportunities' argument. Political institutions are just when they compensate for lack of opportunity caused by misfortunes over which persons have no meaningful control. 'When persons are not responsible for their disabilities,' Beauchamp and Childress argue, 'the fair opportunity rule demands that they receive help to reduce or overcome the unfortunate effects of life's lottery on health.'<sup>20</sup> Institutions must provide, maintain or restore adequate levels of health so that individuals can have access to the normal range of opportunities available to others.<sup>21</sup>

The insertion of political institutions makes this account distinctive. For Daniels, as for Beauchamp and Childress, the right is articulated by reference to political institutions. For Daniels, a right to healthcare is supported by an interest both to be treated in a certain way and to create the institutions that provide such treatment: 'if persons have a fundamental interest in preserving the opportunity to revise their conceptions of the good through time, then they

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<sup>17</sup> Norman Daniels, *Just Health Care* (New York: Cambridge University Press, 1985), 26.

<sup>18</sup> Daniels, 27.

<sup>19</sup> Norman Daniels, *Just Health: Meeting Health Needs Fairly* (Cambridge ; New York: Cambridge University Press, 2007), 29–78.

<sup>20</sup> Tom L. Beauchamp and James F. Childress, *Principles of Biomedical Ethics*, 7th edition (New York: OUP USA, 2013), 263.

<sup>21</sup> Beauchamp and Childress, 271–79.

will have a pressing interest in maintaining normal species functioning ... by establishing institutions, such as health-care systems, which do just that.’<sup>22</sup>

This claim could be read in one of two ways. One is that there are reasons for a general human right to the conditions that advance fair opportunities for all, including healthcare, since human beings have shared features that require respect and protection. The other is that rights to health or healthcare follow from principles that would be chosen by properly situated and motivated agents agreeing to the basic terms of their political relations. On this second reading, Daniels’ account of the right to healthcare is indistinguishable from the contractarian account of rights offered by John Rawls, among others, and it is not necessarily a defense of a universal human right, as I will emphasize below.

#### 4. Contractarian accounts.

For Rawls, basic rights, including rights to basic goods and liberties, are justified by reference to a contractarian decision mechanism. Principles of justice emerge from an original position, in which individuals, suitably idealized to be unaware of their economic position, social status, and other morally irrelevant features such as race, ethnicity, and gender, design institutions to govern their interactions. The decision mechanism operates according to principles that each party agrees are fair, and that fairness transfers to the institutions that are chosen within that mechanism. Although Rawls did not include healthcare in his list of primary goods, nor did he articulate a right to healthcare elsewhere in his theory, a right to healthcare can be derived either from the list of primary goods and liberties as importantly connected to them, or as a corollary of the principle of fair opportunity.<sup>23</sup> Rawls’s original position only applied to societies that shared broadly liberal egalitarian values and had adequate resources to build basic just institutions, so the rights developed in the original position are not universal rights, but moral rights of a qualified sort appropriate to communities that share certain fundamental values and principles, such as a commitment to the equal worth of all human beings, and in the value of liberty and fair opportunity. Understood this way, they occupy an

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<sup>22</sup> Daniels, *Just Health Care*, 28.

<sup>23</sup> Allen E. Buchanan, “The Right to a Decent Minimum of Health Care,” *Philosophy & Public Affairs* 13, no. 1 (1984): 60–61.

intermediary position between universal human rights and conventional-legal rights, the latter understood as the particular protections and entitlements articulated and protected by a specific legal system. But one could extend Rawls's theory to a global original position to generate universal human rights, a move which some of Rawls's followers adopted, but which Rawls himself rejected.<sup>24</sup> Ultimately, however, contractarian accounts are different from other accounts of rights because they are better understood as procedures of how to generate rights instead of substantive account of rights.

Each of these distinctive accounts of rights rest on the assumption that rights serve some single function. But as Nicole Hassoun, Leif Wenar, and others show, we need not accept this assumption. Rights can serve many functions, and accepting a multi-functional account of rights may allow us to reconcile previously incompatible accounts of what rights are for.<sup>25</sup> This insight allows us to proceed on the assumption that each of these accounts identifies an important function of a human right to healthcare without having to solve disagreements between them or show which one is 'best.' The rationales offered for a human right to healthcare are not mutually exclusive.<sup>26</sup>

None of these different accounts of a human right to healthcare require the elimination of all health problems, but there are more and less capacious understandings of what such a right entails, and I will address both the more capacious version and the version of a human right to healthcare that requires the provision of a basic package of goods and services, namely a 'decent minimum.' The accounts outlined above have defended the idea that a right to healthcare gives rise to a claim against one's government for the provision of healthcare services, such as access to medical care, treatment for disease, disability support, and end of life care. That governments are the main duty-bearers of a right to healthcare is far from a conceptual necessity. Indeed, the very idea of a human right requires that all agents, individuals

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<sup>24</sup> Charles R. Beitz, "Rawls's Law of Peoples," *Ethics* 110, no. 4 (July 1, 2000): 669–96; Rawls, *The Law of Peoples*.

<sup>25</sup> Nicole Hassoun, "The Human Right to Health," *Philosophy Compass* 10, no. 4 (April 1, 2015): 277; Leif Wenar, "The Nature of Rights," *Philosophy & Public Affairs* 33, no. 3 (July 1, 2005): 256–251; Tasioulas and Vayena, "Just Global Health," 6.

<sup>26</sup> For an excellent map about recent debates about a moral right to health, see also Benedict E. Rumbold, "Review Article: The Moral Right to Health: A Survey of Available Conceptions," *Critical Review of International Social and Political Philosophy* 20, no. 4 (July 4, 2017): 508–28.

included, are duty-bearers. But individuals cannot in most typical conditions provide healthcare goods and services to one another, since the provision of such goods requires specialized, professional knowledge, large resource investments and a well-developed infrastructure. Understood as a right whose main duty bearers are institutional, a right to healthcare fits uneasily with the condition of institutional independence. If rights to healthcare are rights whose duty bearers are states, companies, and other organizations – as surely, they must be, since such rights cannot be guaranteed otherwise – then rights to healthcare cannot exist in pre-institutional or non-institutional settings, and are not available to stateless people or people living in failed states.

Let us leave this concern aside, and let us assume with the proponents of a human right to healthcare that the human right to healthcare is a right against states and other agents in a position to provide health-related goods and services. Yet institutional capacity cannot be assumed. It depends on resource availability, on the gradual and nested development of networks of infrastructure, education, production, and distribution, and on tradeoffs with other policy goals. By focusing on the right to healthcare in isolation from such constraints, the human right approach cannot explain what kind of institutional capacity is required, namely what the responsibilities of the duties bearers are when it comes to providing healthcare given resource scarcity.

## **II. The Institutional Capacity Condition**

For there to be a human right to healthcare, governments must be able to provide those services that constitute their correlative duty. But the condition is not some abstract ‘ability’ to provide services, but the capacity to provide a specific and uniform set of services across different institutional settings. This condition is demanded by the universality of human rights, in its three dimensions: the universality of right holders, the universality of duty bearers, and especially the equality of treatment (action or abstention) required from the duty bearer.

To see why the idea of a human right to healthcare is problematic, let us start with one of the most authoritative statements of a human right to health, namely that of The

International Covenant on Economic, Social and Cultural Rights (ICESCR). Its Article 12 provides that 'The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.' This includes a requirement that states ensure for all citizens 'medical service and medical attention in the event of sickness.' But many governments lack the resources to provide healthcare services to their citizens. For instance, in Mozambique, where GDP per capita is in the hundreds of pounds and health spending per person in the tens of pounds per year, and where disease is much more prevalent and the available infrastructure much more limited, the provision of healthcare at the level of the 'highest attainable standard of physical and mental health' is an impossible and absurd requirement. The language of Article 12 is unfortunate, as the government of a developing country – even one that manages to secure some important improvements in health levels for its citizens – cannot be expected to achieve the 'highest attainable standard.' As John Arras and Elizabeth Fenton emphasize, this is not even a reasonable policy goal, let alone a human right.<sup>27</sup>

Developing countries face severe resource constraints, in addition to institutional capacity limitations and shortages of trained staff and facilities to deliver health services. Consequently, even if such governments do everything right, allocating their resources appropriately to policing, national defense, and critical infrastructure, they may still be unable to provide their citizens with healthcare services, or services beyond a bare minimum – and therefore would be violating their citizens' rights, without doing anything morally wrong.

The problem is not one of *extreme* scarcity, though. The problem is scarcity itself. Even developed countries with sophisticated healthcare systems face limitations in satisfying their citizens' health needs. Most proponents of a right to healthcare recognize that demand for healthcare is unlimited, so governments must make crucial rationing decisions in allocating limited resources toward unlimited demands for healthcare.<sup>28</sup> Economists have long articulated this problem. Kenneth Arrow has pointed out that guarantees that lift the threshold of access to resources for everyone faces a 'bottomless pit' problem with dramatic consequences for

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<sup>27</sup> John D. Arras and Elizabeth M. Fenton, "Bioethics and Human Rights: Access to Health-Related Goods," *Hastings Center Report* 39, no. 5 (2009): 31.

<sup>28</sup> Beauchamp and Childress, *Principles of Biomedical Ethics*, 280.

resource allocation: “there can easily exist medical procedures which serve to keep people barely alive but with little satisfaction and which are yet so expensive as to reduce the rest of the population to poverty.”<sup>29</sup> Culyer and Wagstaff add that need and equality sit uncomfortably alongside each other in the area of healthcare provision, when individuals need healthcare that improves their health relative to their level of ill health, but distributing healthcare to attain some sort of equality of health defined by normal functioning in a society requires denying individuals healthcare services they need above a certain level.<sup>30</sup> Needs translate into a demand for healthcare services, but the demand is in tension with the requirement for equal access given resource constraints. This leads Culyer and Wagstaff to define need, and indeed equality of access, in terms of “expenditure required to effect the maximum possible health improvement,” and consequently to defend an understanding of healthcare entitlements highly sensitive to resource constraints and the relative cost-efficiency of various health improvement technologies.<sup>31</sup>

Where scarcity leads to denying treatment even for critical conditions, proponents of a human right to healthcare claim such denial is justified as long as the decision results from just or legitimate procedures.<sup>32</sup> For example, like many other theorists, John Tasioulas and Effy Vayena believe that the content of the right is specified mostly through fair social-legal processes: ‘a fully adequate specification [of a human right to healthcare] through pure moral reasoning is typically unavailable; instead, a workable standard must to a significant degree be the product of social decision-making, whether conventional or legal.’

Likewise, for Daniels the right to health implies ‘a socially relative array of services’ that is the outcome of a process of fair deliberation under reasonable resource constraints.<sup>33</sup>

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<sup>29</sup> Kenneth J. Arrow, review of *Review of Some Ordinalist-Utilitarian Notes on Rawls’s Theory of Justice*, by John Rawls, *The Journal of Philosophy* 70, no. 9 (1973): 251. Arrow adopts this point in the context of Rawls’s maximin principle, which requires that a society maximizes the minimum level of resources at which individuals are likely to find themselves no matter what their socio-economic status is. However, the point applies more generally to human rights argument that seek to guarantee a certain minimal (or maximal) provision of goods.

<sup>30</sup> A. J Culyer and Adam Wagstaff, “Equity and Equality in Health and Health Care,” *Journal of Health Economics* 12, no. 4 (December 1, 1993): 436.

<sup>31</sup> Culyer and Wagstaff, 436.

<sup>32</sup> Daniels, *Just Health*; Beauchamp and Childress, *Principles of Biomedical Ethics*.

<sup>33</sup> Norman Daniels, “Health Justice, Equality and Fairness: Perspectives from Health Policy and Human Rights Law”, *The Equal Rights Review* 6 (2011) 134.

Although the absence of health is interpreted as biostatistical deviation from normal species functioning, healthcare entitlements are meant as correctives for individuals achieving the normal range of opportunities available in a given society. The normal range of opportunities are society-relative, and thus healthcare entitlements are society-relative as well.<sup>34</sup> This understanding of a human right to healthcare moves Daniels away from universal human rights, as it denies the ‘universality of treatment’ condition, namely the idea that a universal human right entitles individuals to equal access to healthcare services, regardless of the institutional capacities of their own country.

Focusing on procedures may be the right way to think about allocating scarce resources, but it does not assuage worries that the universality of the right is compromised when rationing involves variability of services within the same country or between different countries. Health officials will need to decide who is entitled to receive care, for what condition, when not everyone can receive care, even when care is a matter of life and death. The relativity of this procedural account of the content of human rights means that individuals will be entitled to completely different health services both across and within nations. Even in a developed country, rationing will make it difficult, if not impossible, for every individual to receive the same level of services or care. The universality of human rights requires equality of treatment, but rationing precludes it.<sup>35</sup>

Faced with this challenge, Daniels may deny that he is defending a *human* right to health. He may simply argue that he is defending a moral right derived from a contractarian decision procedure very much in the Rawlsian spirit that is decidedly non-universal, requiring among others, the presence of certain favorable conditions such as the absence of severe material deprivation, a relatively developed system of public institutions whose role is to implement the society-specific conception of justice, and a modicum of shared norms of

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<sup>34</sup> Daniels, *Just Health*, 58–61.

<sup>35</sup> Proponents of rights to healthcare often ignore the further fact that resource allocation in the absence of easily discernable criteria often privileges powerful interest groups. As John Meadowcroft has shown, in the UK healthcare system, the patterns of allocation of resources prefer those with high socio-economic status to others with more justifiable claims on resources. John Meadowcroft, “Patients, Politics, and Power: Government Failure and the Politicization of UK Health Care,” *Journal of Medicine and Philosophy* 33, no. 5 (2008): 434–41; John Meadowcroft, “Just Healthcare? The Moral Failure of Single-Tier Basic Healthcare,” *Journal of Medicine and Philosophy* 40, no. 2 (2015): 160.



fairness and equality on which such a conception of justice can be built. Thus, Daniels may brush off concerns with equal access to treatment as a condition of the existence of a human right to healthcare by denying that a human right to healthcare is what he defends. If this is the case, Daniels's view shares much more in common with the view I defend in the final section of the article.

But Tasioulas and Vayena, as well as other proponents of a human right to healthcare, will hold steadfast onto an account of this right that is socially and institutionally relative. And they have thoughtfully considered all the problems related to rationing and specification that lead to the relativization of the right to healthcare to the social, political, and economic conditions available in different countries. But they deny that the indeterminacy of the content of such a right and the variability of care should lead us to question the very existence of a human right to healthcare. Developed countries like the UK have procedures for determining when a drug that is safe and effective provides sufficient health benefits to be prescribed to patients as part of their healthcare services underwritten by the government. Some drugs do not provide enough health gains measured in adjusted quality of life years (QALYS) to justify the expense.<sup>36</sup> This strikes Wolff and others as an 'an appropriate, if not entirely uncontroversial, way of allocating resources,' even when the result is that people who need lifesaving treatment are denied it.<sup>37</sup>

This problem has also been addressed in the courts, as Wolff shows. In the South African case *Soobramoney v. Minister of Health*, the plaintiff, a person with acute kidney failure, brought suit against a state hospital that denied him dialysis treatment, arguing that the hospital violated his human right to life and health, both guaranteed by the South African constitution.<sup>38</sup> The hospital had a limited number of dialysis machines, and following an allocation procedure, it denied Soobramoney access to treatment. The constitutional court argued that as long as a fair procedure had been followed, his rights were not violated. Wolff cites the decision approvingly, although he characterizes the situation as a tragic conflict of

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<sup>36</sup> Wolff, "The Demands of the Human Right to Health," 227–29; James Wilson, "The Right to Public Health," *Journal of Medical Ethics* 42, no. 6 (June 1, 2016): 372–73.

<sup>37</sup> Wolff, "The Demands of the Human Right to Health," 228.

<sup>38</sup> Wolff, 228.

rights, implying that perhaps this kind of situation is uncommon and extraordinary.<sup>39</sup> But of course it isn't. *All* decisions involving allocation of resources for healthcare have costs, and therefore require prioritization and, consequently, rationing. Hospital medical boards and national health officials are confronted with them every time they make rationing decisions, namely all the time. A new drug to treat a particular disease might mean fewer beds in the neonatal intensive care unit, or just as dangerous to health and wellbeing, fewer fire crews or fewer police units. Because every allocation has opportunity costs, every allocation has precisely the features of this case. That is regrettable, but it is not unjust.

Proponents of a human right to healthcare conceal this problem when they focus on that right in isolation from its costs in other forgone goods, even those to which persons may also have rights. The result is a search for a maximal level of healthcare, rather than an optimal level given tradeoffs between healthcare and other sorts of goods. Thinking of the right to healthcare as a human right implies that any tradeoff that reduces the share of resources allocated to healthcare is a rights violation.

For Mozambique, whose GDP per capital is in the hundreds of pounds and health spending per person in the tens of pounds per year, where disease is much more prevalent and the available infrastructure much more limited, the provision of healthcare at the level of the UK is simply not possible. Gopal Sreenivasan has articulated this point as a *reductio* of the idea that individuals have claim rights to health. Indeed, he has used precisely the example of Mozambique to show that countries can be entirely 'faultless' in their failure to provide healthcare services that meet their citizens' human rights.<sup>40</sup>

Defenders of a human right to healthcare warn, as Wolff does, that focusing on resource scarcity and its necessary counterpart, cost-benefit analysis, blinds us to ways that drug companies themselves and the international community might make treatments more accessible. The prices of goods and services in the healthcare sector should not be taken for granted, since resources can be shifted to countries with urgent healthcare needs, incentives can be provided for private manufacturers to lower their costs or cross-subsidize lower prices in

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<sup>39</sup> Wolff, 229.

<sup>40</sup> Sreenivasan, "II—A Human Right to Health?," 240–46.

developing countries with higher prices in developed countries, and so on. Cost-effectiveness in such settings is 'itself a problem,' Wolff claims.<sup>41</sup> Yet cost-benefit analysis is both necessary and unavoidable. Ignoring costs means ignoring the adverse consequences on others of decisions made in the course of allocating healthcare goods. Costs are not only measured in terms of monetary resources spent, but in terms of the sacrifices imposed on others, as health economists Alan Williams has argued.<sup>42</sup> So the problem is not cost-benefit analysis as such, but better and worse ways of engaging in it.

Outside resources will help at the margins, even in countries such as Mozambique, by making a difference to the number of those who can gain access to lifesaving treatment for AIDS or malaria. But additional spending by foreign governments or drug companies will never create a *healthcare economy* which supplies the producers (doctors, nurses and other trained staff), facilities (hospitals and clinics) and infrastructure (supply and delivery chains, communications and transport networks) needed to deliver healthcare goods and services. Indeed, even if the amount of outside monetary resources was unlimited, the problem of institutional capacity could not be resolved, because it will depend largely on the structure and health of the overall internal economy, sustained by social, political and cultural institutions, whose quality and capacity will continue to vary greatly from country to country.

International assistance has mitigated some of the significant deficiencies of developing countries in the health service provision area. International organizations, NGOs, pharmaceutical companies, wealthy nations, big private donors have been involved for more than six decades in extensive efforts to provide clean water, vaccines, bed nets to protect against malaria, de-worming medication, tuberculosis and AIDS treatment and prevention, and neo-natal care, to name just a few. And there have been some notable successes, including, the reduction of polio incidence, a disease that affected people in 125 countries in the early 1980s, and irreversibly paralyzed close to 300000 people a year, mostly children. Nowadays more than 99% of the disease has been eradicated, in a global push remarkable for the

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<sup>41</sup> Wolff, "The Demands of the Human Right to Health," 230.

<sup>42</sup> A Williams, "Cost-Effectiveness Analysis: Is It Ethical?," *Journal of Medical Ethics* 18, no. 1 (March 1992): 7.

determination and creativity of its architects.<sup>43</sup> But the reason that this counts as an outstanding success, despite being a single-focus operation that involved countless health providers on multiple continents, national governments in dozens of countries, the World Health Organization, United Nations Fund for Children, the United States Center for Disease Prevention, Rotary International and the Bill and Melinda Gates Foundation, spanning more than three decades, is that it makes a bold contrast with prolonged failures of outside assistance to deliver on healthcare provision to the most deprived regions of the world. The successes must be celebrated and sustained with continued effort and resource commitments, but they represent an incredibly narrow victory given the benchmarks set by considering healthcare as a human right.

The main reason for the lack of success of outside efforts is not only and not even primarily lack of resources. It is the fact that outsiders cannot make up for the very poor infrastructure of health services, lack of political stability, low levels of education or no education infrastructure for healthcare professionals, lack of markets in healthcare goods and services, cultural and social norms that support local uptake of healthcare services even when available for free, and more general infrastructure deficiencies such as lack of accessible roads or electricity.<sup>44</sup> Thus, treating healthcare services as a human right is not primarily a problem of resource scarcity, but one of institutional capacity. The reason why this is primarily a problem of institutional capacity is that even with unlimited monetary resources and good will, it is difficult to see how outsiders could fix the institutional capacity problem. The international community cannot and perhaps should not intervene to build institutional capacity from scratch in countries that lack it.<sup>45</sup>

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<sup>43</sup> Donald G. McNeill Jr. "A Milestone in Africa: No Polio Cases in a Year", *The New York Times*, August 2015, <https://www.nytimes.com/2015/08/12/health/a-milestone-in-africa-one-year-without-a-case-of-polio.html> (accessed February 19, 2018) and "Polio Response in Africa to be Fast, Difficult and Possibly Dangerous," *The New York Times*, August 2016 <https://www.nytimes.com/2016/08/13/health/polio-vaccination-africa-nigeria.html> (accessed February 19, 2018)

<sup>44</sup> Abhijit Banerjee and Esther Duflo, *Poor Economics: A Radical Rethinking of the Way to Fight Global Poverty* (New York: PublicAffairs, 2011); Paul Collier, *The Bottom Billion: Why the Poorest Countries Are Failing and What Can Be Done About It*, 1st ed. (Oxford University Press, 2007); William Easterly, *The White Man's Burden: Why the West's Efforts to Aid the Rest Have Done So Much Ill and So Little Good*, 1st Edition (Penguin Press HC, The, 2006).

<sup>45</sup> They should not because it is hard to imagine well-meaning outsiders being able to make a meaningful difference in the quality of local institutions short of a colonial take-over, which is an illegitimate, and likely unsuccessful solution to improving the quality of healthcare provision on a large scale.

Variable institutional capacity results in the social relativity of healthcare, which belies the claim that 'certainly, people have a human right to such things as access to a healthy diet and treatment for obesity'.<sup>46</sup> It cannot be the case that human beings have rights to very specific services that their governments are not in a position to provide due to decisions made in accordance with just procedures. Even in relatively well-off countries such as the UK or Canada, promoting a healthy diet and obesity treatment might be considered below the priorities set by rationing boards for treating disease and reducing the impact of disability on individual's opportunities. The same could be said about Wolff's blanket statement that individuals dying from AIDS in Zimbabwe have their human rights violated, when according to Wolff's own procedural account of human rights, it is perfectly legitimate for governments to deny treatment to individuals when rationing prevents meeting everyone's health needs.<sup>47</sup> As Gopal Sreenivasan points out, it is 'at once compulsory and indefensible to conclude that the state of Mozambique [or Zimbabwe] is infringing its citizens' moral human right to health.'<sup>48</sup> But human rights cannot go unfulfilled. Indeed, the idea that human rights are rights, means that individuals have claims on others for their fulfillment, and non-fulfilment counts as a rights violation. Due to objective scarcity and institutional capacity constraints, many countries can provide neither access equal to the most developed countries, nor access to basic health services. Since many agents cannot discharge their duties with respect to a human right to healthcare, there is no human right to healthcare.

The lack of resources in developing countries and rationing in developed countries is not just an issue of variability of treatment. It brings out a more general problem for a human right to healthcare, which is the lack of a benchmark by which we can measure whether this indeterminate right is either violated or respected. Perhaps one can claim on behalf of the right bearer that the right is violated in the absence of any service provision whatsoever, and one can assume that there are degrees of respecting the right, but it is hard to see what it would mean to fully and meaningfully respect the right. Is providing some minimal (truly inconsequential) health services to all consistent with respecting a moral right to healthcare?

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<sup>46</sup> Tasioulas and Vayena, "Just Global Health," 21.

<sup>47</sup> Wolff, *The Human Right to Health*, 2.

<sup>48</sup> Gopal Sreenivasan, 'A Human Right to Health? Some Inconclusive Scepticism': 246.

Or does this count as violating most (but not all) of the moral right to healthcare? When is a moral right to healthcare fulfilled/not violated at all?<sup>49</sup>

The next few sections will engage some common answers to these questions that seek to deal with the problem of indeterminacy. What we have ruled out so far is the idea that a human right to healthcare requires a level of healthcare provision that meets the standards of the most developed countries. And clearly, even the most developed states cannot afford to spend to attain the highest achievable standard of mental and physical health. The more general point is that given the social relativity of a right to healthcare, it is at best unclear what is gained by claiming that individuals are due healthcare as a human right. A human right understood in socially and institutionally relative terms is devoid of both content and guidance for the behavior of individuals and institutions, and cannot serve as a yardstick for measuring conformity with moral standards. It ceases to be a human right at all.

### III. The Decent Minimum Guarantee Response

Some might believe that variability in institutional capacity is a problem for a human right to healthcare only if one assumes high universal equal access. Instead, a universal human right might require the guarantee of a *decent minimum* of healthcare for everyone. Yet variability in institutional capacity is a problem for a decent minimum as well as for high equal access. I will show why a decent minimum, however understood, is difficult to guarantee even for the most developed economies, and therefore it will be especially difficult to guarantee for countries with severe resource and institutional capacity limitations. To see why this is so, we must first specify what a decent minimum requires. A decent minimum might (1) guarantee protections against standard threats to health, (2) reduce opportunity gaps generated by diseases which are outside of individual control, or (3) protect the minimal conditions necessary

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<sup>49</sup> Most proponents of human rights to healthcare believe that a combination of theoretical and institutional specification is enough to overcome the problem of indeterminacy. But institutional specification does not make it clear how a human right to health can be a metric for assessing institutional performance, which must be determined without appeals to the specification of the institution thus assessed. For different ways in which proponents address the indeterminacy issues see Madison Powers, "Health Care as a Human Right: The Problem of Indeterminate Content," *Jurisprudence* 6, no. 1 (January 1, 2015): 138–43.

to exercise moral agency with respect to forming and pursuing a normal range of plans of life. These are the best available specifications of a ‘decent minimum’ given the justifications of rights discussed in section one, and the problem with all of them is that the commitments they require are not ‘minimal’ at all.

Let us start with (1), namely standard threats to health that are the most prevalent today. For instance, the top 10 causes of death in the United States (U.S.) are heart disease, cancer, chronic lower respiratory disease, accidents, stroke, Alzheimer’s disease, diabetes, influenza and pneumonia, kidney disease and suicide.<sup>50</sup> Proponents of a decent minimum vastly underestimate both the prevalence and the cost of managing these conditions. A quick perusal of the list reveals that if a decent minimum includes, in addition to routine medical care, treatments for these conditions, any decent minimum is going to involve a very high commitment of resources. Cancer, diabetes, and kidney disease require high cost medical treatments, some of the newest and most expensive drugs and technologies, highly trained specialist care, and a medical system with the capacity to deliver those services. In 2010 in the U.S. the cost of cardiovascular disease alone – including heart conditions, stroke, peripheral artery disease and high blood pressure – was about \$444 billion in combined private and public spending,<sup>51</sup> equivalent to 12% of the entire US federal budget for the year.<sup>52</sup> It is likely that adding up the cost of treatment for all the other conditions will equal or surpass the yearly budget.

Assume now that the point of the decent minimum is (2) to ensure protections only for conditions over which individuals have no control. Many cancers, as well as kidney disease and Alzheimer’s disease fall into this category. Cancer, the second leading cause of death, is estimated to have cost \$78 billion in 2013 in the US.<sup>53</sup> Alzheimer’s disease, a major source of disability later in life, is estimated to affect 1 in 9 Americans over 65, to cost per year of care per patient between \$27,700 and \$47,000, and to have a total cost of care over \$230 billion in

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<sup>50</sup> [https://www.cdc.gov/injury/wisqars/pdf/10lcid\\_all\\_deaths\\_by\\_age\\_group\\_2010-a.pdf](https://www.cdc.gov/injury/wisqars/pdf/10lcid_all_deaths_by_age_group_2010-a.pdf)

<sup>51</sup> <http://www.webmd.com/healthy-aging/features/heart-disease-medical-costs>

<sup>52</sup> <https://www.cbo.gov/sites/default/files/cbofiles/attachments/budgetinfographic.pdf>

<sup>53</sup> [http://www.cdc.gov/cancer/npcr/uscs/technical\\_notes/](http://www.cdc.gov/cancer/npcr/uscs/technical_notes/)

2016.<sup>54</sup> One in 10 American adults has some type of chronic kidney disease, a number consistent with global figures for the prevalence of the disease.<sup>55</sup> End stage renal disease alone cost \$40 billion in 2009 in private and public spending, about 1% of the US federal budget for the year.<sup>56</sup>

Fighting just the three deadliest diseases in the US costs approximately the equivalent of 17%-20% of the US federal budget. The decent minimum will of course be even higher if it includes responding to the other standard threats to health as well. Total healthcare spending in the US surpassed \$3 trillion (in private and public spending) in 2014, almost equal to the whole federal budget.<sup>57</sup> There is no limit to the amount that might be spent on public provision of healthcare, and such amounts cannot be due to people as a human right.

These may be considered unreliable estimates, since the costs of medical care in the US is among the highest in the world. Skeptics will point out that other developed nations, such as the UK or France have lower levels of spending and achieve similar or better results. Developing nations such as Cuba are understood to have good health outcomes with much less spent on medical care than the US, due to a stronger emphasis on preventative care than disease treatment. But it is also true that Cuba reaches these outcome with an intrusive health policy that would be unacceptable in western liberal democracies: yearly health checks for the whole family rely on compulsory house visits, doctors and nurses take detailed notes on the state of individuals' homes and living conditions.<sup>58</sup>

Additionally, the US has close to five times the population of France or the UK, and a higher burden of disease.<sup>59</sup> As percentages of GDP, US, UK, and France have very similar public health expenditures. In 2014, France has spent 9% of its budget, the UK 7.6% and the US

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<sup>54</sup><sup>54</sup> <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3181598/>, <http://www.alzheimers.net/resources/alzheimers-statistics/>

<sup>55</sup> <https://www.niddk.nih.gov/health-information/health-statistics/Pages/kidney-disease-statistics-united-states.aspx>, <https://www.kidney.org/kidneydisease/global-facts-about-kidney-disease>.

<sup>56</sup> <https://www.niddk.nih.gov/health-information/health-statistics/Pages/kidney-disease-statistics-united-states.aspx>

<sup>57</sup> <https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/downloads/highlights.pdf>

<sup>58</sup> "Prevention better than cure in Cuban Healthcare system." BBC News, December 2015. <http://www.bbc.co.uk/news/health-35073966> (accessed February 25, 2018).

<sup>59</sup> See for example <http://ghdx.healthdata.org/gbd-results-tool?params=querytool-permalink/30ab86ea1991c6e9298eb4874f99065a>. (accessed February 25, 2018).



8.3%.<sup>60</sup> The costs are likely to be large and unaffordable for any country that tries to guarantee the basic minimum understood as the protection against the deadliest diseases, many of which require high-tech treatment and the newest, most expensive medications.

But why not define the decent minimum as the best level of funded healthcare available to all citizens that a country can afford given available resources? Countries like the United States spend an average of \$9400 per capita per year on health-related services in public spending alone, while Namibia spends an average of \$500, and Mozambique \$50.<sup>61</sup> If those amounts are the best these countries can do given their resource differentials, then we can count that as the decent minimum. We can leave aside for now the fact that these figures include all public health spending, not just spending on the services that protect against the standard threats to health. There are several problems with this view. First, it is not clear how we can justify that an American is owed \$9400 as a human right to healthcare resources but a Namibian only \$500. We are clearly giving up that universal human rights require equality of access that country with differential resource and institutional capacity endowments cannot guarantee in virtue of their differences. Second, and more important, it seems we are merely saying that whatever countries already commit to healthcare services is what they owe to their citizens as a matter of a human right to healthcare. The right to healthcare loses the capacity to guide and evaluate the choices that governments make in order to fulfill the rights of their citizens.

But perhaps the way to think about a decent minimum is not in terms of protections against standard threats, or compensating for a lack of opportunities that is not in one's control, but (3) as a way to protect the minimal conditions of moral agency for planning and executing a normal range of plans of life. The guarantees that any society can provide will depend, in addition to its available resources and institutional capacities, on other contextual factors such as what is considered a normal range of plans in that society, and what discrepancies there are between various groups in their abilities to make and execute plans

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<sup>60</sup> World Health Organization Global Health Expenditure database, Health expenditure, public (% of GDP), <http://data.worldbank.org/indicator/SH.XPD.PUBL.ZS> (accessed July 4, 2017).

<sup>61</sup> World Bank, 'Health Expenditures per Capita,' 2014 figures, <https://data.worldbank.org/indicator/SH.XPD.PCAP> (Accessed 3.2.2018).

that fall within the normal range. If the gap between those with serious health challenges and those relatively healthy is big, it may be that most resources will be devoted to closing the gap, after which relatively little will be available to ensure anyone else's access in that society to a decent minimum of health services.<sup>62</sup> Or it may be that resources will be devoted to those most likely to need time and resources to form and execute their plans of life, such as the young versus those at the end of their lives, an extremely unpalatable implication.<sup>63</sup> This may mean that in societies with large gaps in health among different groups, healthcare services and goods will be available to protect the condition of exercising moral agency only for the most disadvantaged, while many if not most in those societies can have no or very limited claims to health services.

However we specify a decent minimum of healthcare as a universal right, it becomes difficult to see how even the most advanced, resource rich democracies might guarantee a decent minimum for all their citizens. We need not linger over the situation of developing countries too long to realize that the challenges for them are magnified manifold.

#### **IV. The Progressive Realization Response**

My claim so far is that the resource allocation and institutional capacity problems have far-reaching implications for the defensibility of a human right to healthcare and that specifying a decent minimum is not likely to help overcome it. Some philosophers respond to the resource allocation problem by arguing that we should understand a human right to health in aspirational terms. They adopt the position of some international human rights documents, which claim that even if a human right cannot be fulfilled now, governments should aim to satisfy healthcare demands to the best of their abilities, while keeping full realization in mind as an ultimate goal. This is commonly referred to as 'progressive realization,' and it serves to acknowledge the problem of resource scarcity while keeping states committed to the realization of the human rights in question as a long-term goal.

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<sup>62</sup> Buchanan, "The Right to a Decent Minimum of Health Care," 65–66.

<sup>63</sup> John Meadowcroft, "Just Healthcare? The Moral Failure of Single-Tier Basic Healthcare," 157. See also pp.152–159 for the difficulty of specifying the idea of basic healthcare.

The idea is borrowed from the language of the General Comment 14 of the Committee on Economic, Social and Cultural rights, which replaced the idea of the full realization of rights with the idea of ‘progressive realization.’ Accepting that there may be legitimate reasons why states may not be able to protect its citizens’ right to health due to resource constraints, it nonetheless insists that they have obligations to take ‘deliberate concrete and targeted [steps] towards the full realization of the right to health. While noticing some of the additional problems of indeterminacy with such approach, Wolff for example supports the idea of progressive realization.<sup>64</sup>

Yet by making human rights dependent on future and uncertain resource availability, progressive realization view gives up an essential idea: that we have human rights to healthcare now, that they are universal, and that they accrue to all human beings regardless of what political community they belong to and what resources are available locally. In other words, progressive realization can only work as a new understanding of a human right to health if we give up the features that make it a human right to begin with. This new understanding abandons the idea that human rights generate entitlements that allow people to make claims on others, which create obligations to respect those rights, and which entitle rights bearers to hold violators responsible and ask for reparatory action if those obligations are violated. As Onora O’Neill aptly puts it,

“If we take rights seriously and see them as normative rather than aspirational, we must take obligations seriously. If on the other hand we opt for a merely aspirational view, the costs are high. For then we would also have to accept that where human rights are unmet there is no breach of obligation, nobody at fault, nobody who can be held to account, nobody to blame and nobody who owes redress. We would in effect have to accept that human rights claims are not real claims.”<sup>65</sup>

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<sup>64</sup> Wolff, *The Human Right to Health*, 9–12.

<sup>65</sup> O’Neill, “The Dark Side of Human Rights,” 430.

O'Neill does not say that there is anything wrong with adopting this aspirational or manifesto view of human rights. What she says is rather that this is a new and radically revised understanding of the notion of a human right, and it ceases to have much in common with ordinary understandings of rights. It would appear we can justify a human right to health only if we re-interpret from the ground up what a human right is. We are saving human rights to healthcare by giving up what makes them human rights in the first place.

The progressive realization view would seem to deprive international law of critical leverage in evaluating particular countries' efforts to provide healthcare services for their citizens. But this would not be entirely accurate. This leverage would remain in place at least in situations in which countries make voluntary, specific commitments to public health goals, and international treaties could set up monitoring and enforcement to make sure countries do not backtrack on their commitments. The processes of international law also have value for encouraging countries to undertake such commitments in the first place, by raising the stakes of public accountability, and by giving tools to local activists and citizens to pressure their government to give weight to healthcare provision as part of a larger set of social policies, especially when governments approach such provision in bad faith. But international law is not only important in keeping countries on track with their promises for positive provision of healthcare goods and services, but also in monitoring compliance with legal obligations imposing negative duties not to disable or make people sick. These duties have a longer history and are better established in a variety of international treaties which do not focus strictly on social rights.

Yet it remains true that the progressive realization view demands little for the here and now, and it requires the abandoning of a central feature of human rights, namely its ability to generate claims against others. Moreover, the uncertainty related to the future availability of resources means that in some cases, resources for satisfying healthcare claims might never become available. Economic progress and the building of institutional capacity on which it depends is not guaranteed to be linear nor progressive and it will remain uneven across the world, with the prospect that some countries will remain unable to fulfil their citizens most basic health needs. This will be true even if they do their best to provide as many resources as

possible toward healthcare. It would be wrong under these circumstances to say at any point that these countries violate their citizen's human right to healthcare. We cannot make sense of the idea that individuals living in these unfavorable conditions have a human right to health. Thus, the progressive realization view is much closer to what we would call healthcare as a policy goal than healthcare as a human right view. I will elaborate on this alternative next.

## **V. Healthcare as Legal-Conventional Right.**

The alternative to a human right to healthcare is a legal-political right to healthcare. By legal-conventional right, or conventional right for short, I mean a right that becomes operational once the government becomes statutorily committed to providing a certain service or good to some or all of its population. To take a simple example, governments adopt legislation that create providers of postal services with specific responsibilities towards their citizens, such as the idea that all citizens should have access to postal services. Once governments create postal service through a law generating obligations for mail companies to provide a certain range of services, they acquire duties toward their citizens, and the latter have a claim against the government in case of non-performance. The same is true of many public services directed at specific groups, including housing, healthcare, and disability benefits.

That governments have certain duties to provide healthcare and other services to their citizens does not entail that citizens have prior rights to these services. While rights are certainly sources of duties, not all duties emerge from rights. Indeed, as Benedict E Rumbold explained recently, "the existence of, say, an obligation on society to provide health care to the population, need not imply the population has a right to such care, and rejecting the right to health does not necessarily imply society does not have an obligation to care for the sick."<sup>66</sup> Conventional rights of the kind I describe here indeed emerge from duties that government adopt, rather than the other way around. The guiding principle is that all citizens are at liberty to seek means of provision for goods and services they need, to join with others in doing so and to appoint public functionaries to provide those goods and services. No human right to public

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<sup>66</sup> Rumbold, "Review Article," 510.

provision must accompany a policy that creates healthcare services, but they are provided publicly, and the condition of their provisions are specified, each member of the designated public specified in accordance with those conditions has a claim not to be excluded from access to that service, as well as claims of specific performance against public functionaries.

Conventional rights are rights that depend on membership in political communities, and are rights against specific institutions or political agents that have a statutory duty to promote and enforce them. As such, they are not rights that are invariable across time and space, or that hold against anyone and everyone. Conventional rights are more akin to rights that grow out of contracts, than to moral rights, even if in this case the contracting parties are the citizens on the one hand and the political institutions on the other. Contracts create rights between parties for the performance of the acts to which the parties have committed by contract. Just as contracts create rights and duties for contracting parties, so too legislation creates rights and obligations for citizens and officials respectively. The authority of governments to create and enforce political rights may be based in large part on the moral rights we all have, but the moral rights that justify government authority and the conventional rights that governments articulate on the basis of that authority can be different and can serve distinct functions.

Based on this distinction, I maintain that healthcare is a conventional and not a human right. If it is the case, as most proponents of a human right to healthcare claim, that ‘concrete rights to health-related goods will thus depend on particular institutions within particular socioeconomic contexts, and will have to respond to varying degrees of scarcity and different priorities in different states,’ then a human right to healthcare turns out to do no work at all.<sup>67</sup> The human right approach posits an ideal of healthcare provision and asks, ‘How do we get there from here?’ That gets it precisely backwards: we first need to understand what we can do, and then prioritize among the available options. Of course, the human right approach might be saved with enough qualifications to bring it in line with that perspective, but that is to say that the only hope for that approach is to change into the conventional right approach, focusing on what is feasible and at what cost, and understanding any right to healthcare as emerging from that focus.

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<sup>67</sup> John D. Arras and Elizabeth M. Fenton, “Bioethics & Human Rights,” 31.

States may have a range of good reasons to adopt healthcare as a conventional right. Among those reasons are promoting the general well-being of the population, offering a scheme of social protection for the least well-off and disabled to equalize their life chances, reducing suffering, preventing the spread of contagious disease as a measure of public safety and so on. These reasons may even translate into high priority goals, such as the goal to provide sanitation, clean water or protection against communicable diseases. However highly prioritized those goals are, though, the reasons underwriting them are distinct from any general human right to healthcare, and do not depend on the existence of such a right to function as justifications for a government's commitment to provide healthcare to some or all of its people.

## **VI. Conclusion**

Human rights make certain behaviors mandatory. The idea of mandatory behavior carries the implication that the agent responsible (individual or institution) is capable, under normal circumstances, of discharging its duty. But many governments are not in a position to secure the rights of healthcare for their citizens, whether this right is understood as high equal protection or an equal decent minimum. Therefore, rights to healthcare are best understood as conventional rights, articulated in each political community based on its priorities and available resources, that protect those most vulnerable to sickness, disability and suffering, and that secure to the extent possible a normal range of functioning for all.